BEACON DENTAL CENTER
"A guiding light in dentistry"

Adult Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

Name: _____ Date: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Date of Birth: _____/_____/_____ Sex: ☐M ☐F

Emergency Contact: _____ Relationship: _____ Phone: (_____)_____

Who can we thank for referring you to our office? _____

Previous Dentist: _____ Location: _____ Phone: (_____)_____

Date of last dental exam: _____ Date of last dental x-rays? _____

Dental Insurance

Do you currently have Dental Insurance? ☐Yes ☐No Insurance Provider: _____

Health History

Are you currently under the care of a physician? ☐Yes ☐No

Reason for last visit? _____ Date of last physical examination: _____/_____

Physician Name: _____ Location: _____ Phone: (_____)_____

Medical History

Have you ever been told by a medical professional to pre-medicate prior to dental treatment? ☐Yes ☐No

Have you ever had a serious illness, operation or been hospitalized? ☐Yes ☐No

If yes, please explain: _____

Has there been any change in your health in the last two years? ☐Yes ☐No

If yes, please explain: _____

Have you ever had an allergic reaction to: ☐Medication ☐Food ☐Latex

Other: _____

Have you ever been treated for: (Check all that apply)

☐Blood Pressure: High or Low	☐High Cholesterol	☐Heart Disease	☐Stroke
☐Bleeding/Clotting Disorder	☐Heart Murmur	☐Heart Valve	☐Fibromyalgia
☐Hepatitis	☐Diabetes	☐Depression	☐Tuberculosis
☐Immunocompromised Disease	☐Asthma	☐Rheumatic Fever	☐Dry Mouth

☐Other: _____

Do you now or have you ever used tobacco? ☐Yes ☐No

If you currently use tobacco, are you interested in quitting? ☐Yes ☐No

How many alcoholic drinks do you consume: Daily: _____ Weekly: _____ Monthly: _____

Current Medications: (Prescribed and Over-the-Counter): _____

_____

Women Only: Are you pregnant or do you think you may be pregnant? ☐ Yes ☐No Are you taking birth control pills? ☐Yes ☐No

Who would you recommend to our dental office? Name: _____ Phone: (_____)_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions,, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____